DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/02/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185337	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE COUNTY CARE & REHABILITATION CENTER	249 EAST MAIN STREET BEATTYVILLE, KY 41311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was initiated on 08/17/10 and concluded on 08/19/10. A Life Safety Code Survey was conducted on 08/19/10. Deficiencies were cited with highest Scope and Severity of an "E".	F 000	Lee County Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure that the residents' environment was free of accident hazards. Observation revealed an unsecured soiled linen room on C Hall, which contained hazardous chemicals. Additional observation revealed an unlocked, unmonitored housekeeping cart was found on the Seasons Unit. The findings include: 1. Observation on 08/17/10 at 4:05 PM, revealed the soiled linen room on C Hall was not secured. The door was noticed to have a keypad lock installed, but was not completely closed and was easily accessible. Further observation revealed no staff were in the soiled linen room. The room contained a thirty (30) ounce bottle of lime	F 323		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Glenn Cox — Administrator — 09/14/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 removal; a 2.5 gallon container of Surlite; and, an 18.5 ounce aerosol can of Lift Off in an unsecured cabinet underneath the sink. In addition, observation revealed a door to the laundry room was accessible from the soiled linen room. Review of the Material Safety Data Sheet (MSDS) for the lime removal revealed it contained material which causes damage to the lungs, upper respiratory tract, skin and eyes, and that it may cause burns to the mouth, throat and stomach if swallowed. The MSDS for Surlite revealed it to be harmful or fatal if swallowed, causing chemical burns to the mouth, throat and stomach, as well as the potential to cause blindness if exposed to eyes. Review of the MSDS for Lift Off revealed that the inhalation of the concentrated product could be harmful or fatal. On 08/17/10 at 4:10 PM, an interview was conducted with Laundry Employee #1. Laundry Employee #1 stated she last entered through the laundry room door which was connected to the outside hall, secured by a keypad. Laundry Employee #1 stated the Certified Nursing Assistants (CNAs) used the room to store soiled linens to be laundered. Laundry Employee #1 stated that sometimes the door to the soiled linen room does not fully close due to a difference in air pressure when the washers and dryers were running. In an interview with the Housekeeping Supervisor on 08/17/10 at 4:20 PM, it was revealed that staff were aware of the problem of the door to the soiled linen room on C Hall not closing all the way. The Housekeeping Supervisor stated CNAs	F 323	Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/Specific corrective action. No residents were identified. The Maintenance Director ordered a new, stronger door closure on 8/17/10/09 for the C Wing soiled linen room. The Maintenance Director installed the new door closure on 08/30/10. The Housekeeping/Laundry Director installed a lock on the cabinets containing chemicals on 8/17/10. Housekeeping staff reported the broken lock on the housekeeping cart to maintenance and the lock was repaired on 8/19/10. Address how the facility will identify other residents having the potential to be affected by the same deficient practice/Explanation of steps taken to identify other areas of same deficient practice. Any resident with access to C Wing had the potential to be affected. On 8/17/10, the Maintenance Director and Housekeeping/Laundry Director checked all other areas where chemicals are stored to ensure that	

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F 323	Continued From page 2 use the soiled linen room to store soiled linens, and that CNAs have been reminded to ensure the door was closed. During an interview on 08/18/10 at 10:26 AM with the Housekeeping Supervisor and the Plant Director, it was reported the soiled linen room door on C Hall had been identified as a problem on 04/30/10, during weekly maintenance rounds. The Plant Director stated that stronger door closures had been installed on 05/01/10 in an effort to address this problem. The Housekeeping Supervisor stated she was not aware that chemicals were stored under the sink in the soiled linen room. 2. Observation on 08/19/10 at 9:00 AM, revealed a housekeeping cart on the Seasons Unit to be unlocked and not monitored. Further observation of the cart revealed it contained Lysol 4 in 1; Lysol Foam; a disinfectant; tile cleaner, window cleaner, air freshener, lime remover and scented fresher. Review of the MSDS entry for tile cleaner revealed that it may cause nausea and vomiting if ingested, and was a moderate eye irritant. The MSDS for window cleaner revealed that it contained material which damages the kidneys and liver, and may cause damage to the upper respiratory tract and the central nervous system. The MSDS for lime remover revealed it contained material which causes damage to the lungs, upper respiratory tract, skin and eyes, and that it may cause burns to the mouth, throat and stomach if swallowed. The MSDS for Champion Spray Scents revealed that inhalation may cause headaches, dizziness and nausea. An interview with Housekeeper #1 was conducted	F 323	doors are closing appropriately and chemicals are secure and under lock. On 8/19/10, the Maintenance Director and Housekeeping /Laundry Director checked the other housekeeping carts to ensure the locks were functioning correctly. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 8/27/10, the Housekeeping/Laundry Director in-serviced housekeeping/laundry staff on securing chemicals and preventing resident access to chemicals in the soiled linen room and on the housekeeping carts. Staff were instructed to complete maintenance orders for any door not closing or locking and for broken locks on carts. Laundry staff will check the door to the C Wing soiled linen room and that the cabinets are locked, each shift. Housekeeping staff will check that the locks on the housekeeping carts are working correctly, each day. Any issue will be corrected immediately and reported to Maintenance and the Housekeeping Director.	

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F 323	Continued From page 3 on 08/19/10 at 9:10 AM. Housekeeper #1 stated she left the housekeeping cart unlocked while in a resident's room. She stated that she should have had a key for the housekeeping cart, but the keys she tried didn't work. Housekeeper #1 stated that the cart should be locked to keep residents from getting into it and drinking or exposing them to chemicals. An interview was conducted with the Housekeeping Supervisor on 08/19/10 at 9:30 AM. The Housekeeping Supervisor stated that the locks on the housekeeping carts were replaced in June, and that all housekeepers should have keys to their cart. The Housekeeping Supervisor had extra keys in her office, and attempted to lock the housekeeping cart. It was determined that the lock on the housekeeping cart was broken, as it could not be locked.	F 323	Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. The Housekeeping Director and Maintenance Director will conduct weekly environmental rounds. Any issues identified will be addressed immediately, and results of the rounds reported to the monthly QA committee, with system revisions, staff training, and/or disciplinary actions, as needed. Include dates when corrective actior will be completed.	08/31/10
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329	F329 Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action. Resident #5: The resident had a Dilantin level done on admission and the results were within normal range. On 8/18/10, the Staff Development Coordinator, an RN, called the physician and obtained an order for a routine monthly routine level. The results were also within normal range.	

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F 329	Continued From page 4 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide adequate monitoring of medications for one (1) of twenty-two (22) sampled residents (Resident #5) to ensure the resident did not receive unnecessary drugs. Resident #5 was admitted to the facility on 04/29/10; the physician ordered a serum Dilantin (an anticonvulsant) level to be drawn on 05/04/10. However, the facility did not ensure orders were obtained to monitor the Dilantin routinely. The findings include: Review of the clinical record revealed Resident #5 was admitted to the facility on 04/29/10 with diagnoses which included Renal Failure, Anoxic Brain Injury, Diabetes Mellitus, Cerebrovascular Accident with Paraplegia, Seizures, Alcohol Abuse, and Respiratory Failure. Review of the resident's admission orders revealed an order for the administration of Dilantin 250 milligram via the resident's gastrostomy tube every twelve (12) hours. Further review revealed the physician ordered a	F 329	Address how the facility will identify other residents having the potential to be affected by the same deficient practice/Explanation of steps taken to identify other areas of same deficient practice. On 8/19/10, the Director of Nursing checked all charts of residents receiving Dilantin medication. All other residents had a routine order as recommended by the Pharmacist. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 9/3/10, the Director of Nursing in-serviced all licensed nursing staff on the pharmacy recommendations for medication routine blood levels. Nursing administration staff will bring all physicians orders to the morning meeting for review and discussion of the need of medication monitoring per pharmacy guidelines. The Director of Nursing/Unit Manager will provide the consulting pharmacist with a list of all new admits for recommendation of medication levels.	

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F 329	Continued From page 5 serum Dilantin level to be drawn on 05/04/10, which was within normal limits. Review of the clinical record revealed no documented evidence of orders to obtain Dilantin levels routinely to monitor the medication. An Interview was conducted on 08/19/10 at 9:30 AM with Registered Nurse (RN) #1, the Staff Development Coordinator, and a float staff nurse, who regularly provided care for Resident #5. Further Interview revealed Resident #5 needed Dilantin levels drawn on a regular basis, not just on admission. Further interview revealed she did not know why this had not been addressed for Resident #5. On 08/19/10 at 9:40 AM, interview with RN #2, a staff nurse on Resident #5's wing, revealed continuos monitoring of blood serum levels was necessary on all residents receiving Dilantin. Further interview revealed she did not know why Dilantin levels were not being drawn on a schedule determined by the physician. On 08/19/10 at 10:40 AM, interview with RN #3, the Director of Nurses, (DON) revealed the Unit Manager, along with the wing nurses, were responsible for ensuring necessary laboratory blood levels were drawn periodically on residents by reviewing all new physician orders upon resident admission . The DON further stated all new physician orders were discussed at daily morning meetings and a written log was kept of medications that required therapeutic monitoring. She stated the meetings were held for the purpose of ensuring all necessary protocols related to the orders were followed, such as alerting the doctor that certain additional orders, such as laboratory monitoring, was necessary.	F 329	Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. Medical records will audit 10% of all residents chart weekly to ensure all medication requiring labs is on a routine. Any issue will be addressed, immediately. All findings will be reported to the Monthly QA committee with revisions if necessary. Include dates when corrective action will be completed.	09/10/10

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F 329	Continued From page 6 Further interview revealed the DON was currently responsible for this responsibility, and had overlooked this on Resident #5.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 356	F356 Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action. On 8/19/10, the administrator formulated the correct format for posting the daily staffing. The new daily staffing sheet was visibly posted at the front entrance into the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice/Explanation of steps taken to identify other areas of same deficient practice. No residents were identified to be affected. The new daily staffing sheet was visibly posted at the front entrance into the facility. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	

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F 356	Continued From page 7 Based on observation and interview it was determined the facility failed to post nurse staffing data in the correct format and in a prominent place readily accessible to residents and visitors. The findings include: Observation revealed a central schedule posted in the hallway between the main dining room and the A-B Unit. However, this information was not presented in a clear and readable format understandable by most visitors, nor was it posted on a daily basis and updated each shift. Daily schedules were posted on the A-B Unit, but they were behind closed doors and not accessible to residents and visitors. Observation revealed daily schedules were posted on the Unit C and Seasons Unit. However these were not prominently displayed and were not in the correct format, and were not updated each shift. An interview with the Administrator and the Director of Nursing (DON) on 08/19/10 at 2:35 PM revealed they were unaware of the specific requirements of the regulation. Further interview revealed the facility's posting did not meet the regulatory requirements, and was not prominently displayed and accessible to all residents and visitors.	F 356	On 8/19/10, the Director of Nursing in-serviced the central scheduler on the new staffing format to be placed at the front entrance. Daily staffing sheets will be visibly posted at the front entrance way into the facility. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained The Director of Nursing /Department Managers will monitor the staffing sheet, daily. Any issue will be addressed, immediately. All findings will be reported to the Monthly QA committee with revisions if necessary. Include dates when corrective actior will be completed.	08/31/10
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371	Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action. No residents were identified. On 8/17/10, the Dietary Manager	

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F 371	Continued From page 8 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. During initial tour a bottle of rubbing alcohol was noted to be stored on the bread rack. The walk-in freezer was noted to have ice buildup. The refrigerator in the kitchen was noted to have sealant hanging loose on the inside of the full machine. Dishes were stored wet, and refrigerator #3 was noted to have water dripping from the condenser into 2 full size hotel pans sitting on the top rack of the refrigerator. The findings include: 1. Observation on 08/17/10 at 10:25 AM revealed rubbing alcohol was stored on its side on the bread rack along with loaves of bread. About a teaspoon and a half of the chemical remained in the container. Interview with the Dietary Manager 08/17/10 at 10:25 AM revealed the chemical was used to clean the floor in the freezer because it does not freeze. She further indicated the chemical should not have been stored on the bread rack, it should have been thrown away after staff had finished using the chemical to clean. 2. Observation on 08/17/10 at 10:30 AM revealed stand alone refrigerator #3 had water dripping	F 371	removed and disposed of the rubbing alcohol container on the bread rack. The Dietary Manager notified maintenance of the water dripping in refrigerator #3. On 8/18/10, the Maintenance Director called the refrigerator service company and the refrigerator was repaired. The Dietary Manager removed the four wet coffee cups and five quarter size pans and took to dish room. On 8/17/10, the Dietary Manager removed the loose sealant from the metal rim on the door of the ice machine. On 8/18/10, the Maintenance Director was notified of the loose sealant on the ice machine and was repaired. On 8/19/10, the Dietary Manager removed the ice build up on the back wall of the freezer below the pipe and floor next to the wall. On 8/24/10 the Maintenance Director sealed the areas causing the ice build-up in the freezer. On 8/19/10, the Dietary Manager removed and discarded the package of sweet potatoes with ice build-up on the top of the package. On 8/20/10, the Dietary Manager coached and counseled the Dietary Aide #4 on the proper way to wash hands and then apply gloves.	

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F 371	Continued From page 9 from the condenser and two hotel size pans were stored on the top rack catching the water. Glasses of juice in individual glasses were stored in this refrigerator on the middle and bottom racks, as well as blocks of cheese. Interview with the Dietary Manager on 08/17/10 at 10:32 AM revealed the pans were placed so the water would not leak on anything stored below. She indicated she had maintenance records to document upkeep on the refrigerator. On 08/17/10 at 4:50 PM the Dietary Manager revealed the facility could not locate the previous maintenance records for this particular refrigerator. Interview with the Dietary Manager on 08/19/10 at 3:00 PM revealed she was not sure how long the refrigerator had been leaking, describing it as having been a while. 3. Observation on 08/17/10 at 10:43 AM revealed four (4) coffee cups which were stored wet along with clean dry cups. Interview with the Dietary Manager on 08/17/10 at 10:44 AM revealed the cups should have been air dried before being stored for use. 4. Observation on 08/17/10 at 10:45 AM revealed the ice machine had loose sealant on the inside around the trim of the metal rim on which the door sits when closed. The sealant was hanging loose about five (5) inches in length from the top right side and approximately two (2) inches in length from the bottom right side. Interview with the Dietary Manager on 08/17/10 at	F 371	Address how the facility will identify other residents having the potential to be affected by the same deficient practice/Explanation of steps taken to identify other areas of same deficient practice. Any resident has the potential to be affected. On 8/17/10, the Dietary Manager checked all freezer and refrigerator racks in the dietary area for potential of any hazardous chemical and food contact; none found. On 8/17/10, the Dietary manager in-serviced all staff on proper storage of chemicals and proper discarding of empty containers. On 8/20/10, the Maintenance Director and Dietary Manager inspected all other refrigerators; no water dripping noted in other refrigerators. On 8/17/10, the Dietary Manager inspected the dishes, pots, and pans for wetness; none to be found. On 8/20/10, the Maintenance Director and Dietary Manager inspected all ice machines: no loose sealant noted on the rim of the door. On 8/19/10, the Dietary Manager removed the ice from the back of the wall of the freezer and checked the other freezer for ice build-up.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	186337	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 10 10:46 AM revealed Maintenance changes the filter once a month and dietary staff clean the ice machine once a week. 5. Observation on 08/17/10 at 10:50 AM revealed five (5) quarter size hotel pans stored wet along with clean, dry pans. Interview with the Dietary Manager on 08/17/10 at 10:52 AM revealed the pans should have been air dried before being stored for later use. 6. Observation on 08/17/10 at 10:55 AM revealed ice build up on the back wall below the pipe and ice build up on the floor next to the back wall below the pipe of approximately baseball size. Observation on 08/19/10 at 3:00 PM revealed the ice build up observed on 08/17/10 in the freezer remained present. Interview with the Dietary Manager on 08/17/10 at 10:55 AM revealed the freezer had recently had replacement parts installed. She further indicated the staff had been in the freezer several times and perhaps this was why the ice was present. Interview with the Administrator on 08/19/10 at 3:30 PM revealed the compressor for the walk in freezer had recently been replaced. 7. Observation on 08/17/10 at 11:45 AM revealed ice build up was present on the top of a package of sweet potatoes stored in the walk in freezer underneath the condenser unit. Interview with the Dietary Manager on 08/17/10 at 11:45 AM revealed the sweet potatoes would not be used in the case of ice build up and removed	F 371	On 8/19/10, the Dietary Manager checked all boxes in the freezer for ice; none found. On 8/25/10, the Registered Dietitian in-serviced dietary staff on the proper procedure of hand washing. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 8/20/10, the Dietary Manager in-serviced dietary staff on the proper procedure of storing chemical and hazardous material in the dietary department. The Dietary Manager/Dietary staff will check daily to assure all chemicals are stored properly. On 8/20/10, the Dietary Manager in-serviced dietary staff on the proper way to fill out maintenance orders for any equipment that is not working properly. The Dietary Manager/Dietary staff will complete daily checks on the refrigerator for any dripping water, the freezer for ice build up, and the ice machine for loose sealant. On 8/20/10, the Dietary Manager in-serviced all dietary staff on the proper air drying of dishes and not storing	

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F 371	Continued From page 11 them from the walk in freezer. 8. Observation on 08/17/10 at 5:55 PM revealed Dietary Aide #4 transported a dirty food processor to the dishroom. At 5:59 PM, Dietary Aide #4 was observed to reenter the food preparation area with the clean food processor which she reassembled. Dietary Aide #4 was observed to put on gloves, without washing her hands, and begin to puree bread. Interview with Dietary Aide #4 on 08/17/10 at 5:59 PM revealed she should have washed her hands before putting on the gloves and working with the residents' bread.	F 371	them wet. The Dietary Manager/ Dietary personnel will monitor the proper handling of the clean cups and pans daily. The Dietary Manager/ Nursing Manager will observe for proper hand washing techniques once a day 5 times a week. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained The Dietary Manager will complete weekly reviews in the dietary department to ensure compliance with proper storage of chemicals, hand-washing techniques, equipment is in proper working condition, cups and pans are stored dry. Any issues will be addressed immediately, with findings reported to the monthly QA committee and revision as necessary. Include dates when corrective actio will be completed.	09/10/10

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 08/19/2010. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was a "D".	K 000	Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action. No specific residents were identified. The battery powered emergency light at the end of C Wing Hall did not function when tested. The Maintenance Director notified the September Place that the emergency light on their property was not functioning.	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that emergency battery powered lighting was maintained according to NFPA standards. The findings include: Observation on 08/19/10 at 9:48 AM, revealed the battery powered emergency light at the end of the C-wing Hall did not function when tested. The observation was confirmed with the Maintenance Director. Interview on 08/19/10 at 9:48 AM, with the Maintenance Director, revealed he does a thirty (30) second test monthly for the battery powered emergency light. Further interview revealed the Maintenance Director was not aware of the ninety (90) minute yearly test for battery powered emergency lights. Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure	K 046	Address how the facility will identify other residents having the potential to be affected by the same deficient practice/Explanation of steps taken to identify other areas of same deficient practice. Any resident exiting C-Wing Hall had the potential to be affected. The September place had their maintenance man replace the emergency light on 8/26/10. The Maintenance Director tested the emergency light on 8/26/10.	

RECEIVED
SEP 12 2010
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Glenn Cox — Administrator — 09/09/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 046	Continued From page 1 of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046	The Maintenance checked all exits to ensure none were battery operated, none found. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Maintenance Director will test the battery power emergency light, to included in his monthly rounds for proper functioning. The Maintenance Director will test it for 30 seconds and yearly for 90 minutes. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained The Maintenance Director will log the findings monthly. Any issues identified will be addressed immediately, with findings reported to the monthly QA committee and system revisions as necessary. Include dates when corrective action will be completed.	8/26/10